STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155616	A. BUILDING 00 B. WING	05/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK NURSING AND REHABILITATION	201 E ELM ST NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00107210. Complaint IN00107210 Substantiated, Federal/State deficiencies related to the allegations are cited at F282, F309, 323 and F327 Survey dates: April 30 and May 1, 2012 Facility number: 001145 Provider number: 155616 AIM number: 200120200 Survey team: Anne Marie Crays RN TC Census bed type: SNF/NF: 65 Residential: 27 Total: 92 Census payor type: Medicare: 13 Medicaid: 44 Other: 35 Total: 92 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 5/5/12 Cathy Emswiller RN			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident was transferred to the commode with 2 assist, failed to apply TED hose, and failed to administer Bactrim timely as ordered for a urinary tract infection, for 1 of 4 residents reviewed with plans of care, in a sample of 5. Resident B Findings include: On 4/30/12 at 10:10 A.M., during the initial tour, the interim Director of Nursing [DON] indicated Resident B had recently had a fall from her wheelchair. On 4/30/12 at 10:20 A.M., the interim DON provided a CNA assignment sheet, which included the assignment for Resident B. The assignment sheet indicated: "Assist 2." On 4/30/12 at 11:20 A.M., Resident B was observed sitting in a wheelchair in the dining room. Her right leg was on a footrest, and her left leg was on the ground. The right lower leg appeared slightly reddened and swollen. Neither leg	F0282	F**282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** I. Resident B has had no falls related to transfers and is being transferred with 2 assist. TED hose were obtained and are being applied daily for Resident B per physician's order. Resident B has no s/s UTI. II. All residents requiring 2 person assist and TED hose were identified. Care plans and C.N.A. assignment sheets will be updated to reflect these individualized needs. All residents were reviewed and those residents with labs indicative of UTI are being treated per physician's order. III. C.N.A. assignment sheets, clinical records and care plans were reviewed for transfer needs and TED orders. C.N.A. assignment sheets and care plans will be updated to reflect each resident's current needs for transfer assistance and TED hose placement as applicable. A new lab monitoring system was put into place that includes but is not limited to; receipt of lab results, MD notification and new orders. All new orders will be reviewed daily during IDT meeting to assure proper follow through. All	05/30/2012

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	had TED hose on. During interview on 4/30/12 at 11:30 A.M., CNA # 1 indicated she was ready to transfer Resident B to the commode. CNA # 1 wheeled the resident from the dining room to her bathroom. CNA # 1 proceeded to put a gait belt around the resident's waist, and attempted to have her stand up. Resident B was unable to stand, and CNA # 1 sat the resident down, readjusted the gait belt, and stood the resident up, advising her to hold on to the grab bar. CNA # 1 then sat the resident down on the commode. CNA # 2 then entered the room and asked CNA # 1 if she needed any help. CNA # 1 indicated, "Yes, she's a little shaky today." CNA # 1 also indicated the resident's legs were "usually red," and that the resident "did have TEDS, but I haven't seen them since she got the new chair." On 4/30/12 at 11:45 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, Vascular Dementia, Diabetes Mellitus, and Parkinson's disease. A Physician's order, initially dated 2/7/12 and on the current April 2012 orders, indicated, "TED Knee-High stocking on in the morning and off at bedtime."		nursing staff will be educated on transfer requirements and facility expectations and TED hose placement. All licensed nurses will be reeducated on proper physician order follow through. IV. The Director of Nursing or designee will conduct unannounced audits of 100% of Residents requiring TED hose application, on day shift, daily for 2 weeks, weekly for 2 weeks, monthly for 2 months and then quarterly. The Director of Nursing or designee will conduct unannounced audits of 10% of Residents requiring 2 person assist with transfers, on day shift orevening shift, daily for 2 weeks, weekly for 2 weeks, monthly for 2 months and then quarterly. The Director of Nursing or designee will review all new orders daily to identify new antibiotic orders and proper follow through. The Director of Nursing will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: May 30, 2012	

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	Nurse's Notes included the following notations: 3/19/12 at 3:00 P.M.: "N.O. [new order] received et [and] noted...." A Physician's order, dated 3/19/12, indicated, "Obtain UA [urinalysis]... [with] C&S [culture and sensitivity] if indicated." Nurse's Notes continued: 3/20/12 at 5:00 A.M.: "Attempted x 2 - st [straight] cath, refused, stated, No, No...." 3/20/12 at 11:45 A.M.: ...N.O. to obtain urine per straight cath tonight...." 3/24/12 at 3:00 A.M.: "Resident upset, became upset attempting to st cath, assisted to BR [bathroom]...had large bowel movement, had to disregard use of urine specimen." A Urinalysis report, dated 3/27/12, had a written notation, signed by the nurse practitioner, which indicated, Bactrim DS or renal dose x 10 days for UTI. The report indicated it was faxed on 3/27/12 to the facility. 3/29/12 at 1:00 P.M.: "Spoke with [nurse practitioner] r/t orders for tx [treatment]			

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	of UTI. Order obtained...." A Physician's order, dated 3/29/12, indicated, "Bactrim DS (or renal dose if indicated) x 10 days r/t UTI." 4/4/12 at 5:30 A.M.: "...Faxed Bactrim DS over to pharmacy to dose." 4/4/12 at 12:30 P.M.: "Call received from [name of pharmacist]...received and noted for Bactrim SS Take [one] po [by mouth] BID [twice daily] x 10 days r/t UTI...." The resident's Medication Administration Records [MAR], dated March and April 2012, indicated the resident did not receive her first dose of Bactrim until 4/4/12. An Interdisciplinary Care Plan, initially dated 11/27/11 and updated 4/4/12, indicated a problem of Skin condition, Edema/Weeping, Location bilat [sic] lower extremities..." The Approaches included: "2/7/12 TED hose during waking hrs [and] elevate feet in bed." A Quarterly Nursing Assessment, dated 4/11/12, indicated, "...Edema BLE [bilateral lower extremities] TED hose ordered...Transfers: 2 person assist...Fall Risk Assessment...Total Score 15 ["A score of 10 or more represents high risk for falls"]."			

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A Minimum Data Set [MDS] assessment, dated 4/11/12, indicated Resident B scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assist of two+ staff for transfer, and was totally dependent on two+ staff for toileting.

An Interdisciplinary Care Plan, initially dated 8/15/11 and updated 4/12/12, indicated a problem of "ADL [activities of daily living] Self-Care Deficit AEB [as evidenced by] Needs assistance or is dependent in...Transfer...Toilet use...R/T [related to] Schizophrenia, Weakness, Parkinson's dx [diagnosis]." The Approaches included: "Provide only the amount of assistance/supervision that is needed...Weight bearing, Cueing/prompting...as needed...."

On 5/1/12 at 8:20 A.M., during interview with the interim DON and Administrator, the interim DON indicated Resident B should have been transferred with 2 assist, but that CNA # 1 was nervous. The interim DON also indicated Resident B should have had her TED stockings on, and they were on at that time.

On 5/1/12 at 12:10 P.M., during interview with the interim DON, she indicated she

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	was the person who wrote the order for the Bactrim on 3/29/12 and faxed it to the pharmacy, because she found it on the clipboard on 3/29/12 and realized it had not been sent to the pharmacy. The interim DON did not know why it took from 3/29/12 until 4/4/12 for the Bactrim to be started, but indicated it needed to be "renal dosed" and it was "the pharmacy's fault." This federal tag relates to Complaint IN00107210. 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to ensure a resident who was having frequent loose stools did not continue to receive the prescribed stool softener Colace and laxative Miralax, for 1 of 4 residents sampled for adequate intake and output; and failed to ensure TED hose prescribed by the physician for leg swelling were in place, for 1 of 1 residents reviewed with leg swelling, in a sample of 5. Resident A, Resident B Findings include: 1. The closed clinical record of Resident A was reviewed at 4/30/12 at 3:50 P.M. Diagnoses included, but were not limited to, Altered Mental Status, General Weakness, and History of CVA. Physician's orders, initially dated 3/3/12 and on the current April 2012 orders, indicated, "Miralax 17 GM...take 1 dose daily for constipation," and "Colace 100 mg Take 1 capsule by mouth twice daily	F0309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** I. Resident A no longer resides at this facility. II. TED hose were obtained and are being applied daily for Resident B per physician's order. BM monitoring records were reviewed to identify those residents experiencing frequent loose stools. Clinical records were reviewed to identify those residents with orders for TED hose. III. The Medication Administration Records for those residents experiencing frequent loose stools will be reviewed by Director of Nursing or Designee. The physician for any resident identified as receiving stool softeners and/or laxatives while experiencing frequent loose stools will be contacted with request to hold stool softeners and/or laxatives while loose stools continue. An "Acute Hydration at Risk" policy was drafted and approved by QA committee. C.N.A. assignment sheets will be updated to reflect TED hose placement as applicable. All nursing staff will	05/30/2012

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	for constipation." A Minimum Data Set [MDS] assessment, dated 3/9/12, indicated Resident A had a short-term memory problem, and was totally dependent on two+ staff for transfer and toilet use. The MDS assessment indicated the resident required limited assistance of one staff for eating. The resident's weight was continent of bowels and bladder and her weight was 148 lbs. Nurse's Notes included the following notations: 4/12/12 at 6:20 A.M.: "T [temperature] 99.4 - loose stools x 4 [with] no vomiting noted. Skin pale...Will continue to monitor." 4/12/12 at 8:30 A.M.: "T 100.4. Loose stools cont. Call out to MD regarding status - awaiting return call...Good fluid intake noted. No s/s [signs or symptoms] distress noted." 4/12/12 at 9:00 P.M.: "...N/O's [new orders] rec'd for C-diff x's 2 - 24 hrs apart et [and] repeat U/A C&S. Res. [resident] has had loose stools x's 1 this shift...Will cont. to monitor." 4/13/12 at 8:00 A.M.: "T 99.5. Loose		be educated on Hydration at Risk policy and TED hose placement. IV. The Director of Nursing or designee will conduct unannounced audits of 100% of Residents requiring TED hose application, on day shift, daily for 2 weeks, weekly for 2 weeks, monthly for 2 months and then quarterly. The Director of Nursing or designee will review BM monitoring logs daily to identify residents experiencing frequent loose stools and interventions. The Hydration at Risk committee be interdepartmental in nature and will meet weekly. The Director of Nursing and Hydration at Risk committee will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: May 30, 2012	

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	stools cont. UA C&S pending. No c/o [complaints] voiced this shift...Incontinent of B&B [bowels and bladder] this shift.....Meals fed per staff...." 4/13/12 at 7:30 P.M.: "T 101.8. Conts to have loose stools...DCNP [nurse practitioner] notified by phone et fax. [No] N/O's @ this time...P.O. fluids encouraged. Will cont to observe." 4/15/12 at 2:30 A.M.: "Res. has been awake off & on all evening. T 100.5. Loose stools continue x 2...." 4/15/12 at 11:00 A.M.: "Resident abed...ADLs [activities of daily living] total care per staff. Incont [sic] of b&b...99.3." 4/15/12 at 4:30 P.M.: "Resident lab in n.o. [new order] to send to [name of hospital] to treat & eval r/t [related to] VRE [Vancomycin Resistant Enterococcus] & C-Diff per family request. Resident lethargic, appetite poor [not] responsive to verbal stimuli...." The resident's Medication Administration Record [MAR], dated April 2012, indicated the resident continued to receive the Miralax daily and Colace twice daily on 4/11, 4/12, 4/13, 4/14, and 4/15.			

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	The resident's "BM Monitoring" document, dated April 2012, indicated the following: 4/11/12: Evening shift, 1 large loose [bowel movement], Night shift, 1 medium loose; 4/12/12: Day shift, 2 medium loose, Evening shift, 1 large loose, Night shift, 6 large watery; 4/13/12: Day shift, 1 medium loose, Evening shift, Incontinent, 0, Night shift, 2 large loose; 4/14/12: Day shift, 0, Evening shift, 1 large loose, Night shift, 3 large loose; 4/15/12: Day shift, 2 small loose. On 5/1/12 at 8:20 A.M., during interview with the interim Director of Nursing, she indicated she had inserviced staff in the previous 2 weeks regarding holding the administration of stool softeners and/or laxatives when a resident is having loose stools. 2. On 4/30/12 at 11:20 A.M., Resident B was observed sitting in a wheelchair in the dining room. Her right leg was on a footrest, and her left leg was on the ground. The right lower leg appeared slightly reddened and swollen. Neither leg had TED hose on. On 4/30/12 at 11:30 A.M., CNA # 1 indicated the resident's legs were "usually red," and that the resident "did have TEDS, but I haven't seen them since she			

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	got the new chair." On 4/30/12 at 11:45 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, Vascular Dementia, Diabetes Mellitus, and Parkinson's disease. A Physician's order, initially dated 2/7/12 and on the current April 2012 orders, indicated, "TED Knee-High stocking on in the morning and off at bedtime." An Interdisciplinary Care Plan, initially dated 11/27/11 and updated 4/4/12, indicated a problem of Skin condition, Edema/Weeping, Location bilat [sic] lower extremities..." The Approaches included: "2/7/12 TED hose during waking hrs [and] elevate feet in bed." A Quarterly Nursing Assessment, dated 4/11/12, indicated, "...Edema BLE [bilateral lower extremities] TED hose ordered...." On 5/1/12 at 8:20 A.M., during interview with the interim DON and Administrator, the interim DON indicated Resident B should have had her TED stockings on, and they were on at that time. This federal tag relates to Complaint			

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	IN00107210 3.1-37(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident at risk for falls was transferred with the assistance of two staff, for 1 of 4 residents reviewed for falls, in a sample of 5. Resident B Findings include: On 4/30/12 at 10:10 A.M., during the initial tour, the interim Director of Nursing [DON] indicated Resident B had recently had a fall from her wheelchair. On 4/30/12 at 10:20 A.M., the interim DON provided a CNA assignment sheet, which included the assignment for Resident B. The assignment sheet indicated: "Assist 2." During interview on 4/30/12 at 11:30 A.M., CNA # 1 indicated she was ready to transfer Resident B to the commode. CNA # 1 wheeled the resident from the dining room to her bathroom. CNA # 1 proceeded to put a gait belt around the resident's waist, and attempted to have her	F0323	**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** I. Resident B has had no falls related to transfers and is being transferred with 2 assist. II. All residents requiring 2 person assist were identified. Care plans and C.N.A. assignment sheets were updated to reflect these individualized needs. III. C.N.A. assignment sheets and care plans were reviewed for transfer needs. C.N.A. assignment sheets and care plans will be updated to reflect each resident's current needs for transfer assistance. All nursing staff will be educated on transfer requirements and facility expectations. IV. The Director of Nursing or designee will conduct unannounced audits of 10% of Residents requiring 2 person assist with transfers, on day shift orevening shift, daily for 2 weeks, weekly for 2 weeks, monthly for 2 months and then quarterly. The Director of Nursing will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: May 30, 2012	05/30/2012

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	155616	A. BUILDING 00 B. WING	05/01/2012

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	stand up. Resident B was unable to stand, and CNA # 1 sat the resident down, readjusted the gait belt, and stood the resident up, advising her to hold on to the grab bar. CNA # 1 then sat the resident down on the commode. CNA # 2 then entered the room and asked CNA # 1 if she needed any help. CNA # 1 indicated, "Yes, she's a little shaky today." On 4/30/12 at 11:45 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, Vascular Dementia, Diabetes Mellitus, and Parkinson's disease. A Quarterly Nursing Assessment, dated 4/11/12, indicated, "...Transfers: 2 person assist...Fall Risk Assessment...Total Score 15 ["A score of 10 or more represents high risk for falls"]." A Minimum Data Set [MDS] assessment, dated 4/11/12, indicated Resident B scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The MDS assessment indicated the resident required extensive assist of two+ staff for transfer, and was totally dependent on two+ staff for toileting. An Interdisciplinary Care Plan, initially dated 8/15/11 and updated 4/12/12, indicated a problem of "ADL [activities			

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	of daily living] Self-Care Deficit AEB [as evidenced by] Needs assistance or is dependent in...Transfer...Toilet use...R/T [related to] Schizophrenia, Weakness, Parkinson's dx [diagnosis]." The Approaches included: "Provide only the amount of assistance/supervision that is needed...Weight bearing, Cueing/prompting...as needed...." On 5/1/12 at 8:20 A.M., during interview with the interim DON and Administrator, the interim DON indicated Resident B should have been transferred with 2 assist, but that CNA # 1 was nervous. This federal tag relates to Complaint IN00107210. 3.1-45(a)(1)			

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F0327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on interview and record review, the facility failed to ensure a resident who was having frequent loose stools received adequate hydration, resulting in hospitalization for dehydration, for 1 of 4 residents sampled for adequate hydration, in a sample of 5. Resident A Findings include: 1. The closed clinical record of Resident A was reviewed at 4/30/12 at 3:50 P.M. Diagnoses included, but were not limited to, Altered Mental Status, General Weakness, and History of CVA. A Nutritional Assessment, dated 7/19/11, indicated: "...Weight, 7/18/11 = 146...Nutrient Needs...Fluid (30 cc's/Kg) = 1980 [cc]." Physician's orders, initially dated 3/3/12 and on the current April 2012 orders, indicated, "Miralax 17 GM...take 1 dose daily for constipation," and "Colace 100 mg Take 1 capsule by mouth twice daily for constipation." A Minimum Data Set [MDS] assessment,	F0327	**F327 SUFFICIENT FLUIDS TO MAINTAIN HYDRATION** I. Resident A no longer resides at this facility. II. All residents were reviewed for acute clinical conditions that would place resident at risk for dehydration. These conditions include; prolonged vomiting or loose stools (3+ in 24 hours), Infectious process with elevated temperature that lasts >48 hours, acute decline in food or fluid intake that lasts >48 hours. III. An “Acute Hydration at Risk” policy was drafted and approved by QA committee. This policy includes but is not limited to; determination of acute at risk conditions (prolonged vomiting or loose stools (3+ in 24 hours), Infectious process with elevated temperature that lasts >48 hours, acute decline in food or fluid intake that lasts >48 hours), hydration interventions and monitoring/documentation frequency. Identified residents who were deemed “at acute risk” for dehydration will be placed into the Acute Hydration at Risk program. All nursing staff will be educated on the Acute Hydration at Risk policy. IV. The Director of Nursing or designee will review BM monitoring logs daily to	05/30/2012

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	dated 3/9/12, indicated Resident A had a short-term memory problem, and was totally dependent on two+ staff for transfer and toilet use. The MDS assessment indicated the resident required limited assistance of one staff for eating. The resident's weight was continent of bowels and bladder and her weight was 148 lbs. Nurse's Notes included the following notations: 4/2/12 at 8:45 A.M.: "UA C&S [urinalysis culture and sensitivity] called to MD. Orders received [and] noted for IM Rocephin [antibiotic] 1 gm daily x 7 days for UTI [urinary tract infection]...." 4/10/12 at 2:20 A.M.: "F/U [follow-up] ABT [antibiotic] Complete...Denies itching, burning or pain upon urination. PO [oral] fluids encouraged and taken well. Will continue to monitor." 4/12/12 at 6:20 A.M.: "T [temperature] 99.4 - loose stools x 4 [with] no vomiting noted. Skin pale...Will continue to monitor." 4/12/12 at 8:30 A.M.: "T 100.4. Loose stools cont. Call out to MD regarding status - awaiting return call...Good fluid intake noted. No s/s [signs or symptoms]		identify residents experiencing frequent loose stools and interventions. The Director of Nursing or designee will review 24 hour report sheets daily to identify residents experiencing conditions increasing risk for dehydration and interventions. The Hydration at Risk committee be interdepartmental in nature and will meet weekly. The Director of Nursing and Hydration at Risk committee will report to QA committee weekly for four weeks, monthly for two months and quarterly thereafter. V. Date of Completion: May 30, 2012	

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	distress noted." 4/12/12 at 9:00 P.M.: "...N/O's [new orders] rec'd for C-diff x's 2 - 24 hrs apart et [and] repeat U/A C&S. Res. [resident] has had loose stools x's 1 this shift...Will cont. to monitor." 4/13/12 at 8:00 A.M.: "T 99.5. Loose stools cont. UA C&S pending. No c/o [complaints] voiced this shift...Incontinent of B&B [bowels and bladder] this shift.....Meals fed per staff...." 4/13/12 at 7:30 P.M.: "T 101.8. Conts to have loose stools...DCNP [nurse practitioner] notified by phone et fax. [No] N/O's @ this time...P.O. fluids encouraged. Will cont to observe." 4/15/12 at 2:30 A.M.: "Res. has been awake off & on all evening. T 100.5. Loose stools continue x 2...." 4/15/12 at 11:00 A.M.: "Resident abed...ADLs [activities of daily living] total care per staff. Incont [sic] of b&b...99.3." 4/15/12 at 4:30 P.M.: "Resident lab in n.o. [new order] to send to [name of hospital] to treat & eval r/t [related to] VRE [Vancomycin Resistant Enterococcus] &			

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	C-Diff per family request. Resident lethargic, appetite poor [not] responsive to verbal stimuli...." The resident's Medication Administration Record [MAR], dated April 2012, indicated the resident continued to receive the Miralax daily and Colace twice daily on 4/11, 4/12, 4/13, 4/14, and 4/15. The resident's "BM Monitoring" document, dated April 2012, indicated the following: 4/11/12: Evening shift, 1 large loose [bowel movement], Night shift, 1 medium loose; 4/12/12: Day shift, 2 medium loose, Evening shift, 1 large loose, Night shift, 6 large watery; 4/13/12: Day shift, 1 medium loose, Evening shift, Incontinent, 0, Night shift, 2 large loose; 4/14/12: Day shift, 0, Evening shift, 1 large loose, Night shift, 3 large loose; 4/15/12: Day shift, 2 small loose. The resident's "Food/Fluid Consumption Record," dated April 2012, indicated the resident had the following 24 hour fluid intake: 4/11/12, 360 cc, 4/12/12, 660 cc, 4/13/12, 660 cc, 4/14/12, 120 cc, 4/15 refused. A hospital history and physical, dated 4/16/12, indicated, "...Reason for admission: Clostridium difficile, vancomycin-resistant Enterococcus in the			

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	urine, dehydration...History of present illness:...was sent to the emergency room last night because of VRE in the urine...was found to be in acute renal insufficiency...Laboratory and Imaging Studies:..Admitting BUN was 97 [normal 1-24] and Creatinine 2.3 [normal .6-1.5]...." 2. On 5/1/12 at 10:10 A.M., the Administrator provided the current facility "Hydration at Risk Policy," dated April 2012. The policy included: "To assure each resident receives adequate fluids to prevent dehydration to the extent the resident's condition makes this possible...Each resident shall have a plan of care in place to address identified risk factors for dehydration. 3. The Registered Dietician shall calculate upon admission, annually and with any significant change in condition each resident's estimated fluid needs. 4. A resident shall be deemed 'Hydration at Risk' under the following conditions: a. Prolonged vomiting and/or loose stools (3+ episodes in 24 hours) b. Infectious process with elevated temperature that lasts >48 hours. c. Acute decline in fluid intake that lasts >48 hours...5. Hydration at Risk residents shall have the following initiated: a. I&O [intake and output] monitoring...." On 5/1/12 at 10:10 A.M., during			

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	interview with the Administrator, she indicated this policy had been implemented in the previous 2 weeks, and prior to that, there wasn't a hydration policy in writing. The Administrator also indicated hydration had been recently addressed in the facility's quality assurance program. This federal tag relates to Complaint IN00107210 3.1-46(b)			

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